The REDE model of healthcare communication: Optimizing relationship as a therapeutic agent

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Abstract

The REDE model is a conceptual framework for teaching relationship-centered healthcare communication. Based on the premise that genuine relationships are a vital therapeutic agent, use of the framework has the potential to positively influence both patient and provider. The REDE model applies effective communication skills to optimize personal connections in three primary phases of Relationship: Establishment, Development and Engagement (REDE). This paper describes the REDE model and its application to a typical provider-patient interaction.

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Introduction

Effective communication is the foundation for any relationship in healthcare, and our ability to consistently deliver high-quality care requires that this relationship be strong and meaningful. A significant tradition of work on the therapeutic alliance, patient-centeredness and relationship-centered care has long recognized the healing potential of the healthcare relationship.1 In our experience teaching relationship-centered communication to thousands of seasoned clinicians, we nonetheless recognized that many providers did not intuitively view forming relationships with patients as their role, nor did they perceive benefits of this mode of communication. In addition, in a world intensely focusing on patient experience, providers often feel left out. Subsequently, building upon the previous theoretical and empirical work, we constructed a model that put the concept of relationships in healthcare at the forefront. To further reinforce the concept, we directly correlated phases of the healthcare relationship to phases of the medical interview and communication skills therein. Emphasizing the premise that genuine relationships are a vital therapeutic agent,[2,3] use of this framework has the potential to positively influence both patient and provider.

The REDE model

The REDE model of healthcare communication is a conceptual framework for teaching and evaluating relationship-centered communication. REDE harnesses the power of relationships by organizing the rich database of empirically validated communication skills into three primary phases of Relationship: Establishment, Development and

Engagement (see Figure 1).[4, 5, 6] Many models of healthcare communication exist.[7, 8, 9, 10, 11, 12, 13, 14] In our experience, several considerations led to the design of REDE, its resonance with advanced clinicians and implications for teaching. First, REDE is informative and also transformative because it challenges users of the model to explore their own assumptions and beliefs about patients and their role as providers. Second, we recognized that seasoned clinicians have performed countless interviews and often developed an unconscious competence in communication. Our teaching of REDE appreciates the skills clinicians already have, intentionally models relationship-centered communication in our facilitation method and encourages reflective competence by providing a common language that allows providers to reflect and refine their own skills. Third, the REDE model characterizes communication skills as tools in a toolbox, to be applied as needed. For the healing power of a relationship to be optimized, the skills must be presented in a manner that is genuine and authentic. If every provider was encouraged to recite the same lines of welcome, patients would perceive them as rote and impersonal. At the same time, we acknowledge that in early stages of learning, most newly introduced behaviors can feel scripted or unnatural until they become automated from repetition and practice. For ease of recall and utility, REDE also includes a mnemonic for each relationship phase that further supports the principles of relationship-centered care, as we have found, not unexpectedly, that learners codify information differently, and some appreciate explicit verbiage. Fourth, the REDE model can be generalized to a variety of settings. Because adult learning theory has shown that anchoring new information in what is already known facilitates learning,[15] REDE skills can easily be woven into the traditional medical interview (See Figure 2) in both outpatient and inpatient settings and used across settings in a variety of conversations.

Phase 1: Establish the relationship

Creating a safe and supportive atmosphere is essential for making a personal connection, fostering trust and collaboration. The emotion bank account is a concept originally proposed by psychologist and author John Gottman, Ph.D. It refers to a mental system for tracking the frequency with which we emotionally connect with other people.[16] Each time an emotional connection is made, it is equivalent to making a deposit in the emotion account with that person. Building up the emotion account is important to sustain a personal connection. This way, when a withdrawal inevitably occurs, such as when a patient is forced to wait to see a provider, the emotion account does not automatically go into the red.

Convey value and respect with the welcome. In doing so, we are essentially building the emotion bank account with our patients and families. Given that people form first impressions very quickly and patients are discussing emotional and value-laden topics, how we set the stage for conversation matters, even it feels irrelevant to the clinical problem(s) at hand.[17, 18, 19, 20] The skills outlined in Phase 1 are intended to create a climate conducive to the development of trust by demonstrating that the provider is receptive and interested in the person first, patient second.

Collaboratively set the agenda. Many providers fear this practice will sacrifice time necessary for assessing or treating the primary concern. However, research has shown that sharing in agenda setting not only facilitates partnership but also improves visit efficiency, diagnostic accuracy and patient satisfaction.[21] Sharing in the agenda setting helps minimize our tendency to presume what a patient's concerns are and in what order of priority.

Introduce the computer. The electronic health record is a reality for most healthcare providers. How we introduce and utilize the computer should be explained as a means of enhancing patient care rather than detracting from it.

Demonstrate empathy. Empathy is the ability to imagine oneself in another's place and to understand that person's thoughts and feelings. In his book, "Empathy and the Practice of Medicine," Howard M. Spiro, M.D., described empathy as "I and you becomes I am you or I might be you (p. 9)."[22] Substantial research has examined the importance of empathy. Human beings are hard-wired to be empathic toward one another.[23] Unfortunately, we also know that, without intervention, empathy declines through medical training, over time in practice and with task pressure.[24, 25, 26] Our experience is that most providers care about their patients, but not all recognize emotional cues or respond to them. Making verbal statements of empathy has been shown to reduce the length of both an outpatient surgery and primary care visit.[27] In REDE, every opportunity to convey empathy is encouraged, and the mnemonic SAVE is introduced for outlining different types of empathic statements a provider can use.

Phase 2: Develop the relationship

Genuine curiosity and interest are the necessary first steps in relationship building. However, once a safe and supportive

Figure 2. The REDE Model and the Traditional Medical Interview

Relationship:																
Establishment				**Development**								**Engagement**				
Open	Build rapport	Elicit concerns	Negotiate & set agenda	CC	HPI	PMH/ PSH	Meds & allergies	FH	SH	ROS	Physical Exam	CC Manage-ment	DX	Education	Shared Decision Making	Close
Empathy																

Note: CC = chief complaint; HPI = history of present illness; PMH/PSH; past medical history/past social history; Meds = medications; FH = family history; SH = social history; ROS = review of systems; Dx = diagnosis.

environment has been created, the relationship needs to evolve and grow. Getting to know who the patient is as a person and understanding that person's symptoms in a biopsychosocial context is the next step. Developing the relationship also requires continued deposits into the emotion bank account and, thus, ongoing use of empathy.

Listen reflectively. Shown to enhance the therapeutic nature of a relationship, increase openness and the disclosure of feelings and improve information recall,[28, 29, 30] reflective listening is vital for developing the relationship. Yet listening in such a way as to understand and acknowledge what is being said can be a deceptively complex and challenging skill.

Elicit the patient narrative. Obtaining the history of present illness (HPI) can quickly become a series of closed-ended questions that are of most interest to the provider.[31, 32] However, the goal of this skill is to better understand the patient's perspective on his or her symptoms. This has been proven more efficient and effective than a provider-centered data gathering approach.[33]

Elicit the patient's perspective. Explanatory models are values, beliefs and experiences that shape a person.[34] Being curious to explore and open to learn are key to knowing the person, their illness that is a social response to disease and the disease itself. The REDE model suggests a simple mnemonic VIEW to explore the patient's perspective.

Phase 3: Engage the relationship

The last step in relationship building aligns with the education and treatment portion of a patient encounter. Relationship engagement enhances health outcomes by improving patient comprehension and recall,[35, 36] capacity to give informed consent,[37] patient self-efficacy,[38, 39, 40] treatment adherence and self-management of chronic illness.[41, 42, 43]

Share diagnosis and information. Telling a patient the medical facts and what he or she needs to know is not sufficient for effective care. We must also be sure the patient understands the information. Framing information in the context of the patient's perspective and engaging in dialogue that allows the patient to register new information and ask clarifying questions facilitates patient understanding.[44, 45, 46, 47]

Collaboratively develop a plan. Relationship engagement is designed to support patient understanding, decision making and consideration of potential treatment barriers. Treatment adherence and behavior change are more likely when the patient is an integral part of the planning process and agrees with the recommendations.[48]

Provide closure. Ending a visit can easily be taken for granted. However, reviewing the time spent and demonstrating respect and appreciation for the patient provides closure and engenders continued partnership.

Dialogue throughout. Patients are unable to comprehend and accurately recall a considerable amount of information presented during a typical medical visit.[49, 50] Dialogue, as opposed to monologue, keeps the patient involved in the learning process[51] and, more important, reflects the importance of the patient's role as head of his or her treatment team. In REDE, the sequence for engaging in this dialogue throughout the education and treatment portion of a patient visit is summarized by the mnemonic ARIA.

Summary

Effective communication is necessary to deliver safe, high-quality medical care. At the core of effective communication is the ability to develop meaningful relationships with patients. The REDE model builds on a significant research base including placebo, therapeutic alliance, communication

Figure 1: The REDE Model Skills Checklist

<table>
<tr><th colspan="3">Relationship:</th></tr>
<tr><th>Establishment
Phase I</th><th>Development
Phase II</th><th>Engagement
Phase III</th></tr>
<tr><td>Convey value & respect with the welcome
Review chart in advance & comment on their history
Knock & inquire before entering room
Greet patient & companions formally with smile & handshake
Introduce self & team; clarify role(s)
Position self at patient's eye level
Recognize & respond to signs of physical or emotional distress
Attend to patient's privacy
Make a brief patient-focused social comment, if appropriate</td><td>Engage in reflective listening
Nonverbally – e.g., direct eye contact, forward lean, nodding
Verbally using continuers such as
"mm-hmm", "I see", "go on" or reflecting the underlying meaning or emotion of what is said –
"What I hear you saying is…" or "Sounds like…"
Avoid expressing judgment, getting distracted, or redirecting speaker
Express appreciation for sharing</td><td>Share diagnosis & information
Orient patient to the education & planning portion of the visit
Present a clear, concise diagnosis
Pause if necessary
Provide additional education, if desired & helpful to the patient
Frame information in the context of the patient's perspective</td></tr>
<tr><td>Collaboratively set the agenda
Orient patient to elicit a list of their concerns
Use an open-ended question to initiate survey
Ask "What else?" until all concerns are identified
Summarize list of concerns to check accuracy; ask patient to prioritize
Propose agenda incorporating patient & clinician priorities; obtain agreement</td><td rowspan="2">Elicit the patient narrative
Use transition statement to orient patient to the history of present illness
Use open-ended question(s) to initiate patient narrative
Maintain the narrative with verbal & nonverbal continuers –
"Tell me more…" or
"What next?"
Summarize patient narrative to check accuracy</td><td>Collaboratively develop the plan
Describe treatment goals & options including risks, benefits, & alternatives
Elicit patient's preferences & integrate into a mutually agreeable plan
Check for mutual understanding
Confirm patient's commitment to plan
Identify potential treatment barriers & need for additional resources</td></tr>
<tr><td>Introduce the computer, if applicable
Orient patient to computer
Explain benefit to the patient
Include patient whenever possible (e.g., share labs or scans)
Maintain eye contact when possible
Stop typing & attend to patient when emotion arises</td><td>Provide closure
Alert patient that the visit is ending
Affirm patient's contributions & collaboration during visit
Arrange follow-up with patient & consultation with other team members
Provide handshake & a personal goodbye</td></tr>
<tr><td>Demonstrate empathy using SAVE
Recognize emotional cues & respond "in the moment"
Allow space to be with the patient & their emotion without judgment
Clarify the emotion if needed
Recognize emotion evoked in you & refrain from trying to fix or reassure
Demonstrate verbally with SAVE
Support -"Let's work together…"
Acknowledge -"This has been hard on you."
Validate -"Most people would feel the way you do."
Emotion naming -"You seem sad."
Nonverbally - doing only that which feels natural & authentic to you</td><td>Explore the patient's perspective using VIEW
Vital activities –
"How does it disrupt your daily activity?" or
"How does it impact your functioning?"
Ideas –
"What do you think is wrong?"
Expectations –
"What are you hoping I can do for you today?"
Worries –
"What worries you most about it?"</td><td>Dialogue throughout using ARIA
Assess using open-ended questions
What the patient knows about diagnosis & treatment
How much & what type of education the patient desires/needs
Patient treatment preferences
Health literacy
Reflect patient meaning & emotion
Inform
Tailor information to patient
Speak slow & provide small chunks of information at a time
Use understandable language & visual aids
Assess patient understanding & emotional reaction to the information provided</td></tr>
</table>

skills and patient-centeredness that recognizes the healing potential of the healthcare relationship for not only patients but also providers. The REDE model helps frame the specific communication strategies that optimize their effect(s) on processes, outcomes of care and the patient-provider relationship itself. The REDE model also encapsulates evidence-based communication practices and our experience with seasoned clinicians, mostly staff physicians, within a large hospital system. It is hoped that such systemwide efforts will result in improved experience of care and self-efficacy for patients, and increased confidence, emotional connectedness and resiliency for providers. Future research will examine the generalizability of the REDE model for different contexts and provider types, as well as its potential to impact patient and provider outcomes.

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